# SUBSTANCE ABUSE MEDICAL REPORT

**P-142S REV. 5-2001**

STATE OF CONNECTICUT
**DEPARTMENT OF MOTOR VEHICLES**
*MEDICAL REVIEW DIVISION*
On The Web At http:// dmvct.org

**TO: Department of Motor Vehicles, Medical Review Division, 60 State Street, Wethersfield, CT 06161-2510**

| PATIENT'S NAME | DATE OF BIRTH | TELEPHONE NO. |
|---|---|---|
| | | |

| ADDRESS | WHEN WAS PATIENT LAST EXAMINED BY YOU? |
|---|---|
| | |

HOW LONG HAVE YOU BEEN TREATING THIS PERSON?

ARE THERE ANY DISORDERS SUGGESTING IMPAIRMENT OF PERCEPTION, ATTENTION, CONCENTRATION, JUDGMENT, HALLUCINATIONS, DELUSIONAL THINKING, USE OF MEDICATIONS, OR DRUGS WHICH MIGHT INTERFERE WITH THE SAFE OPERATION OF A MOTOR VEHICLE? ☐ **YES** ☐ **NO** *(Please Explain)*

**MEDICATIONS** *(Please indicate dosage)*

☐ **ANTIDEPRESSANTS** ☐ **ANXIOLYTICS** ☐ **MOOD STABILIZERS** ☐ **METHADONE**
☐ **NEUROLYTICS** ☐ **SEDATIVES** ☐ **ANTABUSE** ☐ **NALTREXAN** *(Trexan)*

DOES PATIENT CURRENTLY SUFFER FROM CONVULSIVE SEIZURES? ☐ **YES** ☐ **NO**

**GIVE DATE OF LAST EPISODE** — MONTH | YEAR | TYPE

DO YOU BELIEVE PATIENT UNDERSTANDS THE SIGNIFICANCE OF HIS/HER DISORDER? ☐ **YES** ☐ **NO**

DO YOU BELIEVE PATIENT IS COMPLIANT IN USE OF PRESCRIBED PRESCRIPTIONS? ☐ **YES** ☐ **NO**

DO YOU HAVE REASON TO SUSPECT THE PATIENT ABUSES ALCOHOL, MEDICATIONS, OR ILLICIT DRUGS? ☐ **YES** ☐ **NO**

**Please report the person's pattern of use of alcohol and other chemical substances subject to abuse. Will it adversely affect his/her capacity to safely operate a motor vehicle?** ☐ **YES** ☐ **NO** *(Please explain)*

**Of what other relevant medical, surgical, or psychiatric illnesses are you aware?** *(Use additional sheet of paper if necessary)*

**Does this person have a deteriorating condition?** ☐ **YES** ☐ **NO** **If yes, specify condition and indicate how often he/she should be re-examined.**

DOES THE PATIENT ACKNOWLEDGE EVER HAVING HAD ANY MOTOR VEHICLE ACCIDENTS? ☐ **YES** ☐ **NO**

**IF YES TO QUESTION ABOVE, WHEN DID THESE ACCIDENTS OCCUR?**

TO YOUR KNOWLEDGE, HAS PATIENT EVER HAD A LICENSE DENIED OR REVOKED? ☐ **YES** ☐ **NO**

| DENIAL OR REVOCATION INFORMATION, IF YES ABOVE | YEAR | STATE | REASON |
|---|---|---|---|
| | | | |

**What is your opinion about this person's ability to operate a motor vehicle safely? Under what circumstances may he/she do so?** *(Please elaborate)*

**Do you feel that an independent evaluation of this person's fitness to drive is desirable?**

| PHYSICIAN'S NAME *(Please Print or Type)* | OFFICE ADDRESS *(Include Zip Code)* |
|---|---|
| | |

| TELEPHONE NO. | PHYSICIAN'S LICENSE NO. | PHYSICIAN'S SPECIALTY |
|---|---|---|
| | | |

| PHYSICIAN'S SIGNATURE | DATE REPORT COMPLETED |
|---|---|
| X | |